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ABSTRACT

The purpose of this study was to develop a "Foster Community" which is a small town in which local residents welcome ex-psychiatric patients and interact with them in a manner that evokes no community censure or disruption of personal life styles. The first facet consisted of the organization of a series of activities to reduce the social distance between patients and members of the community, and the development of a foster home program. The second facet was the establishment of a resocialization and remotivation program to ready patients for community placement. Continuing medical, psychiatric, and social services were provided to insure the maintenance of community cooperation and maintenance of the patient at the appropriate level of functioning. The town of New Haven, Missouri, was developed into a foster community and presently seventeen patients are in the program. Results thus far demonstrate that: (1) a community can be induced to sponsor such a program, (2) enlightened community attitudes follow from direct exposure to patients, (3) families offer homes and support independent living arrangements in the town, and (4) a patient's condition improves further with a planned resocialization and remotivation program. (author/RSM)

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FOSTER COMMUNITY FOR MENTAL PATIENTS:

A NEW HAVEN

by

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INTRODUCTION:

It has become increasingly evident that, with modern concepts of mental illness and available biological, and psychological, and social treatment methods, psychiatric hospitalization should be considered an episode in the life of the individual patient and should be kept to a minimum. It is no longer a matter of much controversy that the social adjustment of the psychiatric patient to the hospital environment is dysfunctional when he is returned to the community. In order to prevent this from happening, it has been suggested that not only should the beginning of treatment be directed toward the suppression and control of the florid symptoms, but also a rehabilitation program emphasizing social adjustment and development of s ocial and vocational skills should be initiated simultaneously.(1) As soon as the symptoms are brought under control, it is advisable to return the patient to the community, especially when community aftercare resources are available.(2) This is true, not only for the newly admitted patient, but also for a large number in the chronic population of the mental hospitals who have improved under new drugs, psychotherapeutic and social treatment methods. These patients no longer require custodial care and should be released from the hospital. As mentioned by Kraft, et al,(3) explicit plans for chronic patients have not been clearly spelled out, and the hope that either

they will be entirely eliminated or greatly reduced in numbers on the basis of the new comprehensive community mental health plans has not been substantiated. For some decades, efforts have been directed toward finding an adequate rehabilitation resource for this type of patient. For rehabilitation at the community level, various transitional facilities and after-care programs were developed. Among them were half-way houses, occupational and industrial rehabilitation, nursing homes, and foster family care. Unfortunately, each program has been limited not only by appropriatness as a discharge resource, but also by the degree of community receptivity to the discharged mental patient. For example, the question of half-way houses or hostels becoming quasi-institutions that perpetuate the isolation of the patient from the community has been raised.[4,5] The placement plans following employment, particularly in chronic patients with long histories of illness and hospitalization, often times are found to be unrealistic.[6,7,8,9] Placement with the patient's family, although desirable, is usually unavailable, especially among long-term chronic patients. Two circumstances mitigate against primary dependence on families as placement resources; 1) The family is the environment in which the symptoms were first manifest and, 2) Families may reluctantly comply with medical advice, and without sincere concern for the patient, which may precipate early rehospitalization.[10,11] In the majority of these chronic cases the phenomenon of "desocialization"[12] of the hospitalized patients results in severance or loss of family connections. Another placement resource, the nursing home, although seemingly convenient

for aged and physically disabled patients, is not considered suitable for those patients who are relatively young and in good physical health. Thus, for those patients with few outside resources, foster family care appears to be the most suitable means of getting out of the hospital.

Foster family care is an ancient rehabilitation resource for the mentally ill. Historically, it originated in Gheel, Belgium, centuries ago and in the United States goes back to colonial times. It is assumed that through foster home placement the chronically ill may lead more normal lives and may be provided with a bridge to eventual independence. However, despite the obvious and apparent suitability of foster homes, difficulties have been encountered in such areas as recruitment of homes, patient turn-over in the homes, urbanization, and modern style of life. Other stumbling blocks in the realization of foster care programs as rehabilitation resources include, public attitudes, the fear of mental illness,[13,14] and the role of the foster family with respect to the community and institution. The foster family is customarily scruitinized in great detail by the institution and supervised to insure that its performance is in the best interest of the patient. The family, meanwhile, is vulnerable to criticism from other community members who may see the family as jeopardizing the interests of the community for their own financial benefit. For its efforts, the foster family generally receives a low rate of pay, in addition to whatever humanitarian reward they are able to gain under these prevailing circumstances. However, the main difficulty seems to be in the recruitment of new foster homes.

This is evidenced by the experience of St. Louis State Hospital in the

last year. Nursing homes are readily available and placements there are numerous; where as, placements in foster homes are, by comparison, negligible. At the end of the fiscal year, June 1969, St. Louis State Hospital had 985 patients in nursing homes and 33 in foster homes. Contrarily, most professional staff would prefer foster home placements for those patients between 40 and 55 years of age who are unable to live independently and are currently in nursing homes. We are faced with a major gap in available community services for the rehabilitation of that group of middle-aged patients who either remain in the institution, or are farmed out to nursing homes because no other resource exists.

It is assumed that the purpose of rehabilitation efforts for the psychiatrically handicapped individual should be directed toward his achieving an adequate level of adjustment on his return to the community; in other words, he should be able to participate in society to the fullest extent of his capabilities. It is however, recognized that in many cases the level of functioning will be limited. This limitation in functioning may be caused either by residual symptomatology, or by social isolation from the community. In order to deal with these difficulties both the patient and the community require re-education to permit mutual interaction, acceptance and support. Several authorities on after-care of the chonic mental patient have cautioned against premature discharge without adequate provision for after-care,(5) against an irresponsible policy of discharge without regard to facilities for resettlement resulting in loss of public support for essential after-care services,(4) against the incautious discharge of the mentally ill which can have tragic

repercussions on the family.[15] An essential ingredient to successful after-care is an adequate and appropriate rehabilitation program prior to discharge. To further document the need for a relevant after-care program, a recent investigation within the culture of rural Missouri in 1966,[16] demonstrated considerable reluctance on the part of rural Missourians to interact in an intimate fashion with persons who had been identified as mentally ill.

It seems obvious, therefore, that any successful plan to place patients in a community must ultimately rest upon the extent to which citizens of the community could come to interact with patients in a manner which was different than that of the prevailing rural norms. Essentially, they must be willing to admit patients into their community, their circle of friends, and in some instances, to actual inclusion in the family circle. To do that, it has been hypothesized that any program which would be effective in changing people's attitudes toward the mentally ill would have to contain the two essential elements of <u>contact</u> and <u>service</u>.[17] As Titmuss pointed out while criticizing the English forms of community care,[18] "to scatter the mentally ill in the community before we have made adequate provision for them is not a solution in the long run".

With this concept in mind, a pilot demonstration study has been undertaken to find a way to remedy the lack of community resources for the chronic patient. The main purpose of the study is to develop a "Foster Community". Foster Community, as used in this paper is a conceptual term describing a small town and its surrounding area, in which local residents welcome ex-psychiatric patients and interact with them in a manner that evokes no community censure or disruption of personal life styles. In essence the attitudes

in and environment of the foster community are ones which minimize the exclusion and maximize inclusion of the discharged mental patient in community life. To most effectively use this resource, i.e., the foster community, a rehabilitation program geared specifically toward the foster community has been developed. Thus, this program is composed of two basic elements; 1) the development of a foster community, and 2) a rehabilitation program. We wish to stress that neither element of the program is exclusive of the other; patients cannot be rehabilitated without involvement in the community and the community cannot be re-educated without involvement with the patients.

Development of the Foster Community:

It was assumed that if persons in the community were provided with opportunities for contact with, and services to, the ex-mental patient, and would receive attention and recognition for their efforts, rather than censorship, social isolation or financial loss, considerable interest and activity would be forthcoming. Another major assumption held that each party in the relationship should be able to further his own self-interest within the context of the relationship by means of representation and involvement in planning.

At the outset of the project, the major task was the selection of the foster community. The criteria for the selection of the community were; 1) population, under 5,000; 2) distance, not more than one hour driving time from the hospital; 3) ecologically an autonomous and stable community economically independent of St. Louis, evidencing cohesiveness, community

spirit and interest in human welfare. Since the intent was to involve the entire community, it was felt that these criteria would insure definable geographic boundaries, would facilitate the discovery of local leadership, and would provide a situation in which the communication network could be comprehended. Further, it was anticipated that an autonomous small town would be less confusing to the patients and that the patient would not pose an economic threat to those people employed in community industries. Finally, it was essential that the town chosen, historically had been successful in community ventures.

The next logical step to follow the selection of the town, was individual contact with people in the community, in order to establish a community organization. The purpose of the organization was to sponsor and facilitate the integration of ex-mental patients into the community. This was to be achieved by educating the citizens through direct contact with patients in hopes of developing a more tolerant and accepting community. Positive support by the majority of community leaders was necessary for the successful development of the community into a fostering and sponsoring one. In working with these leaders through existing organizations, a general exposure to the proposed program was sought. When it was determined by these key individuals that a positive disposition toward the program existed, and that there was no significant resistance, the nucleus of the organization began to function. One of the major purposes of the organization was to represent the community in its dealings with the hospital. To establish a balanced partnership with the hospital it was preferable that the organization become a recognized corporate entity, therefore, the status of a not-for-profit cor-

poration was realized. Incorporation, additionally, encourages financial support by the community, since donations are tax-deductable.

Following the formation of the town organization, a series of activities were progressively undertaken in order to reduce the social distance between patients and the members of the community with the ultimate goal being the opening of placement homes for the patients. The program was carried out through the various sub-committees of the organization in constant consultation and in close collaboration with the project staff. The activities were directed first toward modifications of the prevailing cultural modes of response to mentally ill persons. To this end, publicity through news media, speakers, presentations to organizations, public schools, social gatherings, etc., were used to pave the way for interaction between community members and the patients without undue fear or censorship. The individual patients were gradually introduced into the town and subsequently included in the community and homes with the ultimate goal of placement.

Development of Resocialization Program in the Hospital:

A number of studies,[19-23] referring to the behavior of chronic psychiatrically hospitalized patients, indicate that, like people everywhere, these patients adapt to the environment to which they are exposed, and use their adaptive ability to adjust to a hospital setting. Over the years, the institutionalized patient develops acceptable patient behavior. Their interest turns to intra-hospital happenings, and they usually become essentially passive and non-assertive in their dealings, using their symptoms as a basis of social exchange with others. The major task of the resocialization and remotivation

program, in the hospital, was undoing institutionalized behavior.

The rehabilitation program relies primarily on the establishment of a group as the mode for treatment. The rationale for using the group approach is that the group provides an opportunity for reality based social exchange with more than one other person, which is a necessity for family living. Within this context essential skills for daily living were taught and the use of symptomatology as a basis for social exchange was discouraged. Patients were confronted with the realistic ramifications of a history of psychiatric hospitalization and were charged with the responsibility to educate the community about mental illness through their daily behavior. The existing norms of the community were used as a basis of evaluating appropriate behavior; for example, middle aged women in New Haven do not wear white bobby sox and saddle oxfords to social gatherings; this could be concretely demonstrated, to the patient. The differences between "hospital behavior" and "outside behavior" were clearly and frequently defined; "outside behavior" was rewarded. Finally, the patient was helped to view himself as a potential community member rather than a patient, for, he must begin to change his environmental orientation before he can see any need to attempt to modify his behavior to facilitate social performance in the community.

With these principles in mind, the resocialization and rehabilitation program of the New Haven Foster Community Project proceeded according to the following steps.

At the outset of the project it was essential that the patient selection be carefully made in order to avoid undesirable and uncontrollable

behavior that could be detrimental to the community acceptance of the program. Patients were referred from all units of the St. Louis State Hospital Complex and were screened by a committee.

The criteria for the selection included: 1) both sexes; 2) age range, 25 - 55 years; 3) length of illness, 5 years or more; 4) no destructive behavior or physical acting-out since symptoms were considered stabilized; 5) intelligence within normal range with some ability to make decisions; 6) some ability to communicate with others in order to follow a conversation and simple instructions; 7) no history of alcoholism or drug addiction; 8) not involved presently in other rehabilitation programs.

Those who met the criteria were formed into separate working groups of 3 to 5 patients, and were included in Phase I of the program, which was a trial acceptance period of 4 to 8 weeks duration. During this phase, social interaction and activity programs were conducted. The patients continued to reside in their wards and attended three meetings a week. The emphasis was on the program, and the identification and learning of tasks needed for independent daily living both in the hospital and in the town. This phase also included a discussion of patients' reservations regarding the program, and attempted to help them to come to grips with mental illness and its ramifications outside the hospital. Social interaction with other members of the group and project staff was also assessed. At this phase, behavioral demands upon the patient were minimal, and consisted of attending scheduled meetings, maintaining a reasonable level of self-care and personal hygiene, and putting into practice those skills learned at group meetings. Sometime during this phase, they

attended a social event in the town. At the end of the period, the case was reviewed and the patient either advanced to Phase II or was dropped from the program.

In Phase II the patient was then formally accepted into the program and moved to the Missouri Institute of Psychiatry (MIP) Research ward, which was sexually integrated, well staffed, and provided services to patients on an individualized basis. Activities included, in addition to those previously described, proper attention to personal hygiene and clothing care, including doing their own laundry and responsibility for their belongings. Being housed on the same ward enabled them to work out a division of labor and to plan activities among themselves with decreasing direction from the staff. They were given self-passes to move in and out of the hospital grounds. They were expected to show group cohesiveness and to spend time away from the ward, in the community immediately surrounding the hospital, or in the city shopping, or taking advantage of recreational opportunities. They also began to visit the town more regularly for special occasions or overnight visits. The duration of this phase ranged from 4 - 8 weeks. To gain experience in inter-dependent living, the patients were then included in Phase III. They moved from the MIP ward to two small apartments which are located on the hospital grounds. One apartment was assigned to male patients and the other to female patients, with shared kitchen facilities. Informal staff supervision was provided as needed. The patients were expected to continue their weekly meetings with the staff to discuss apartment problems, their concerns relative to anticipated placement, recreational activities, responsibilities for meals, and taking their medication. They were encouraged towards individual initiative and

assuming responsibility.

Those who complete this phase of the resocialization program, were then considered ready to move into the community for placement.

Maintenance:

The maintenance of the program in the community divides itself into two areas of concern. 1) Follow-up services to the discharged patients and foster families and, 2) ongoing development of the community as a resource. Follow-up services are dispensed through weekly contact with all patients by a staff member at a regular group meeting. This meeting provides patients the opportunity to air their grievances and maintain friendships with other participants in the program. These meetings are informal and relaxed and staff is able to evaluate the level of functioning in a natural and familiar setting. The staff is available to foster families on call, and the foster families meet as a group six times a year. Informal supervision is provided by community members who are often consulted regarding minor problems before staff members are contacted.

Development of the community as a resource entails regular meetings with key committee members, participation in the monthly organizational meeting and the monthly recruitment committee meeting. Input of staff time is necessary in developing new weekend homes and in encouraging weekend homes to consider the possibility of becoming full-time foster homes. Routine follow-up of "regular" weekend homes is now carried by community members. As the program becomes a recognized part of the community, new modes of interaction between patient and community are continually explored with the community assuming greater responsibility for the facilitation of these ideas.

To maintain interest in the program, encourage participation and dispense information, the project relies heavily on a weekly column in the local newspaper. Additional coverage is provided by a local radio station. These activities were initiated and have been maintained solely by townspeople.

As the program becomes more firmly established in the community, the emphasis of developmental activities shifts. When the program was new and unknown much staff time was spent alleviating the anxiety of community members regarding interaction with mental patients. This is no longer problematic and is exclusively the responsibility of community members.

To provide a creative rehabilitation program in the hospital required administrative support for flexible and unconventional approaches to patient care and treatment. The type program undertaken could only occur in a progressive hospital environment.

RESULTS:

Selection and development of the foster community: At the beginning of 1968, at the request of the Missouri Division of Mental Diseases, a survey of 5 towns was initiated with the intention of developing a foster community. From this survey, the town of New Haven, Missouri was selected. It is a small, attractive, active rural town with an approximate population of 1,500, located on the banks of the Missouri River, about 60 miles west of metropolitan St. Louis. The economic base of the community is industrial, although a sizeable minority continue farming.

After a brief study of the selected town, a local clergyman was contacted regarding the feasiblity of a foster community, and he suggested contacting the

leading industrialist. Through them a meeting with other key townspeople, including the mayor, two other clergymen, and the newspaper editor, was arranged. This led to a town-wide meeting, to which representatives of all local organizations were invited, as well as other persons whose involvement with the program would be expected, such as the pharmacist, the physicians, etc.. Also present at this meeting, were representatives of the Missouri Division of Mental Diseases, St. Louis State Hospital and Department of Psychiatry of University of Missouri Medical School. At this meeting, community support for the program was endorsed. A town council was unofficially formed to work toward the establishment of the foster community through publicity and personal contacts. This town council subsequently became a non-profit organization, The New Haven Foster Community Project, Inc., (NHFCP,Inc.), whose purpose was to work in partnership with the hospital staff for the rehabilitation and re-integration of ex-patients into the community. One of the project staff has been actively involved with this corporation since the beginning and has attended all their meetings.

The establishment of direct contact between the community and the patient was necessary for the success of the program. Therefore, after the formation of the town organization, the following series of activities were progressively undertaken to reduce the social distance between patients and the members of the community.

1) Speaking engagements - in order to promote understanding and interest in the program, the project staff participated in 21 engagement in the form of presentation and discussion sessions at local clubs, church groups, and public schools. Similar presentations were made to professional groups

in the hospital with the inclusion of community council members to present the community point of view. For example, in such meetings the questions ranged from primitive fears of "crazy people" to the nature of mental illness. 2) A weekly feature column - written by interested town residents, has been carried in the local newspaper, The New Haven Leader. This column covered regular news items of the program in the town and pertinent articles on mental health topics supplied by the staff.

Following their initial introduction into the town, meetings between patients and townspeople were arranged through social gatherings such as luncheons, ice-cream socials, bar-b-que outings, etc.. Twelve such community events have been sponsored, including five community-wide affairs and seven activities by individuals or families. This sort of arrangement allowed the contact to take place under circumstances wherein community members could make as little or as much investment as they wished toward the patients and the program.

More intimate and individual contacts were possible through sponsor homes. The sponsor homes have provided two facilities: 1. Weekend homes - through the efforts of recruitment committee, 19 different patients made a total of 117 visits to the town. Thirty-two of the town's approximate 450 families provided 102 weekend homes and 10 offered day visits to their homes, within the 18 months of the program period. 2. Permanent foster homes - the preparation of the families and the patients has been arranged so that each family had several contacts with various patients and vice-versa. In this way, the sponsor families and patients could mutually select each other, thus insuring some level of compatibility between them prior to becoming permanent

homes. Families who desired to become foster homes made their intent known to the project co-ordinator through the recruitment committee. The selection and acceptance was based on the interest shown the patient, the family's social performance in the community and ability to interact with the patient, as well as patient's reciprocal desire to live with the family. Prior to finalizing the placement, extended visits with the family occurred. The family was given basic information regarding the patient, his illness and financial arrangements. When both the family and the patient were adequately prepared, a contract was signed between the hospital and the family. Five patients have been placed in such foster homes since the start of the project.

Independent living arrangement: An alternative placement for patients in the foster community recently occurred with the assistance of the Corporation, because of a shortage of foster homes. A four-room apartment was rented. The initial financial support was provided by local organizations and industries. Continued funding will be through, Division of Mental Diseases, Welfare, Social Security, and patient's own resources. The apartment was furnished through donations from the townspeople and the hospital. Two patients now reside there, and informal supervision is provided by the community.

The seven ex-patients live as new citizens, or as they are called "new residents" in the town. Through the help of various interested citizens and local groups who are in constant touch with them, they participate in the daily activities of their foster families or of the town. Additional services indicating the town's support of the program are manifested in other ways. For community

members who were unable to have direct involvement with the patients, the opportunity for more indirect involvement with the program was available. For example: One of the local physicians has provided office space for the project. Furniture and appliances for the patients' apartments at the hospital and in the town were donated. Community recreational and public facilities were open to the patients. Transportation of the patients to local activities, meetings, and shopping has been provided by various individuals in the community.

Hospital Resocialization Program: Parallel to and simultaneous with the development of foster community and its activities, the hospital part of the project dealt with the selection and preparation of patients through a resocialization and remotivation program. This initially included a relatively small number of patients. This was done for the purpose of developing adequate basic procedures with emphasis on individual patients. During the first 12 months of the project, 51 patients, (28 female and 23 male), were referred to and screened by the selection committee on the basis of previously mentioned criteria, to which some flexibility was allowed, i.e., for age, if the patient was found to be suitable otherwise. Twenty-five met the criteria and 26 were rejected. The population characteristics of these patients are shown in Table I. Female and male patients as well as accepted and rejected groups, in general, did not differ much in regard to age, duration of illness, hospitalization, and disgnostic categories. The majority of these patients were chronic, long term hospitalized schizophrenics. They had little interest in or motivation for life outside the hospital. There were no social resources for them, their family ties were lost or minimal. Except for two, the majority were indigent.

A few had a history of stable work at one time or another in the past, but the majority were unskilled.

In Table II, the movement of the 25 patients accepted into the program is shown. Ten patients have completed all phases and have been placed outside the hospital. Of these, seven are in the foster community. Five have lived with foster families for a period of 6 to 16 months, and two were moved into an independent apartment two months ago. Three male patients, who required closer supervision for their care could not be placed in the foster community, but as they benefitted from the program a great deal, they were able to move together to a boarding home in the city. All patients placed to-date have been active and helpful within their foster families or within their neighborhoods. They are accepted members of the social circles of the foster families, churches, and local organizations. Although primary emphasis has not been upon employment, one patient has been employed full time at a local factory for more than a year and has become self-supporting. Another has obtained employment at the local school, and a third one is employed part-time. These performances must be interpreted in light of the fact that the seven patients in question were chronic schizophrenics with an average age of 46 years, a history of illness averaging 24 years, and 15 years of continuing hospitalization. Although each had initial adjustment difficulties within the first 3 months, none has been re-hospitalized to the extent of dropping from the program. The relapses in symptomatology that were seen in three patients one time or another within the first six months, were mainly due to self-induced discontinuation of their prescribed medication. Their condition was restored quickly following a brief rehospitalization of 3 - 7 days

duration, for readjustment of chemotherapy. The relationship between the patients and the families were strong and these episodes created no negative attitudes in either the patient or the family and the return to the foster community was welcomed by both. During the progress through various phases of the resocialization and remotivation program, five patients were dropped on Phase I. One had secured employment outside; one refused to participate in the program; in two, exarcerbation of the psychotic symptomatology occurred; and one was found to be intellectually too limited to cope with program demands. During Phase II, as the stress and demand of the program increased, two patients became extremely disturbed and unable to follow their schedule and were dropped. In Phase III, one patient, as the placement time approached, refused to take her medication, her psychosis increased and she had to be discontinued from the program. Presently there are three patients in Phase II, three patients in Phase III. The staff has spent an average of 35 hours a week in the town, working with townspeople, families and individual ex-patients for the development and maintenance of the foster community services.

Evaluation of the Program:

A systematic data collection procedure has been developed to permit the evaluation of the results of the project. It was hoped that such data analysis would allow compilation of theoretical and practical information from the perspective of the patient, the family, the community, the hospital, and the professional staff. At the present time, we are in the process of such data collection and analysis which will not be mentioned here in detail. However, from the results so far obtained, there seems to be sufficient evidence to indicate

that some of the primary goals of the project were achieved. For instance, as outlined earlier, the major aim of developing the selected town as a "Foster Community", has been achieved. The two areas that substantiate it are: 1. Formation of a sponsoring local organization; the "New Haven Foster Community Project, Inc.", which has been instrumental in providing sponsor families, placement facilities and numerous other social activities by creating an environment of acceptance between the community and the state hospital patients. This local organization acts as a partner with the hospital and represents the community in planning for the patients. Thus,a community based fostering organization has been established for the ex-hospital patients. 2. Positive attitude toward the program has been developed; although no statistical or wide range assessment has yet been made, a recent survey of the attitude toward, and willingness to, participate in the program has been made in a sample of 33 families who have heard or had contact with the project. Thirty-one of them indicated willingness to actively participate in some capacity and the other two indicated passive support. None of them checked a response choice indicating the belief that the project was contrary to the best interests of the community. This result is considered as evidence of the positive attitude of the residents of the community.

On the hospital side, the resocialization program for the preparation of the patients for community living was successfully carried out simultaneously with the development of the foster community. The adequacy of the preparation of patients for outside life has reflected itself in the relatively smooth transition from the hospital to community life, particularly in the seven placed patients. The main difficulties encountered with the patients were related to the secondary

gains of long hospitalization and the lack of sufficient individualized treatment in the past. In most cases a thorough medical, psyhciatric, and social review were essential for the readjustment of an appropriate treatment and training program for the individual patients. The majority of the patients who came in contact with the program were able to be remotivated for outside living, particularly once they reached the second phase.

Despite these promising initial results, many problems remain to be dealt with. For example, time schedules for each phase of the program could not be maintained as planned because individual patient's required different lengths of time to adjust to the new situations. The slowness of openings of foster homes in the town caused delay in the movements of the patients in the hospital facilities. In this respect, the flexibility toward using other resources than foster homes, such as renting independent living quarters in the town appears to be a promising development. In view of the prevailing life-style of American families, i.e., becoming more insular and nuclear, independent living arrangements in the foster community may become the primary placement resource.

Although many patients could not be accomodated in the program, those who have been involved with it have shown remarkable improvement in their condition and adaptive capabilities. From our experience with these chronic patients, it seems that the primary limitation is in our ability to accurately predict their rehabilitation potential. Once proper opportunity is given to them they surpass the most optimistic expectations.

The easy access to staff by patients, families and community members

probably was the major factor in the prevention of recidivism and maintenance of foster homes in the face of psychiatric crises.

Such a program requires close interdisciplinary work and considerable time and manpower investment. The initial small number of patients served may raise the question of its economical feasibility. It is too early to answer this question positively or negatively. We tend to see it as the initial investment that promises further growth with time and perseverence. The main encouraging factor, in this respect, has been the response and cooperation from the townspeople toward the program and the patients. For example, at the start of the program, for the first weekend visit to town of 4 patients, it took 40 telephone calls to secure 3 weekend homes. Presently, 5 - 10 patients are easily accomodated on any weekend with 10 - 15 calls.

The program is an excellent educational experience for the staff, community members, and students interested in mental health, community organization, community psychiatry, and rehabilitation.

SUMMARY AND CONCLUSION:

This pilot demonstration study intended to develop and test the feasibility of a new approach to providing community resources for the rehabilitation of the chronic, but stabilized, psychiatric patients who lack outside social means. This approach involves three-facets which are simultaneous and inter-related.

1. A community organization approach was used for the development of a foster home program to give the patients and the community the opportunity to accept each other. This has taken into consideration that knowledge that

public attitudes regarding mental illness tend to be negative and that foster homes hold less than desirable positions with other members of the community. Such attitudes have a jeopardizing effect on the re-integration of the "ex-mental patient" into the community. Through planned intervention and informal education of the community, with the assistance of local organizations, a favorable attitude toward patients was developed for their acceptance into the community.

2. The second facet was the development of a re-socialization and re-motivation program to ready patients for community placement. This task was accomplished by; a) building social skills -- by providing experiences within and outside the hospital which progressively approximated community living; and, b) handling concerns regarding social functioning and placement -- through the use of group therapy techniques.

3. Continuing medical, psychiatric, and social services have been provided to insure the maintenance of community cooperation and maintenance of the patient at the appropriate level of functioning.

The results, so far, have been encouraging. A small (population 1,500) progressive rural town, New Haven, approximately one hour driving distance from St. Louis, was developed into a "foster community" working actively with the hospital staff. The informal community council formed in March 1968, has developed into "New Haven Foster Community Project, Inc.". Its members have been active in publicizing the program, and providing social activities to aid in the acceptance and integration of patients into the community. They have also recruited weekend homes for patient visits, foster homes for placements,

meeting locations, written a regular column in the local paper, and provided office space for use of all involved. In this pilot phase, 19 patients made 117 visits to the town, of which 102 were weekend visits using 32 homes in the community.

The rehabilitation program committee screened 51 patients, accepting 25 for Phase I, which consists of an initial preparatory step for active rehabilitation. Of these, 10 patients have completed Phase III of the remotivation and resocialization program. Five have been placed with families, 2 live in an apartment in the foster community. Another 3 were placed in a boarding home. Of the remaining, seven continue in the hospital phases of the program and 8 were initially dropped from the program because of their psychosis or incompatibility with the program.

Results thus far demonstrate; a) a community can be induced to sponsor such a program; b) enlightened community attitudes follow from direct community exposure to patients; c) families do offer homes to patients, but also support independent living arrangements in the town; d) a patient's condition improves further with a planned active resocialization and remotivation program.

TABLE I

Population Characteristics

		Screened	Accepted	Rejected
Sex	Male	23	8	15
	Female	28	17	11
Age (yrs)	Range	16-64	26-58	16-64
	Mean	46.7	46.8	46.5
Length of Illness(yrs) (since lst hosp.)	Range	3-42	8-38	3-42
	Mean	21.1	21.1	20.7
Total yrs. in Hosp.	Range	1.3-37.0	1.3-37.0	2.3-28.0
	Mean	12.8	14.3	11.2
Diagnostic Categories:				
Schizophrenia		43	23	20
Affective Dis.		1		1
Org. Brain Syndr.		4	2	2
Mental Retard.		1		1
Mental Retard. (Secondary to Psychosis)		(2)	(1)	(1)
Other (Neuroses, Personality Dis.)		2		2

TABLE II

PATIENT MOVEMENT

(N:25)

		Entered		Completed		Remain		Dropped	
		M	F	M	F	M	F	M	F
Preparation in Hosp. (Resocialization Program)	Phase I	8	17	6	14			2	3
	Phase II	6	14	4	10	1	3	1	1
	Phase III	4	10	4	6		3		1
Placement In Foster Other Community	Foster Home	1	4						
	Apartment		2						
	Boarding Home	3							

REFERENCES

1. Burton, W.E., Administration of Psychiatry - Springfield, Ill., Charles C. Thomas.

2. Braceland, F.J., Rehabilitation - Amer. Handbook of Psychiatry III:652-653, Basic Books, N.Y., 1968.

3. Kraft, A.M., Binner,P.R., Dickey,B.A., "The Chronic Patient" - in R.H. Williams and L.D. Ozarin (Eds), - Community Mental Health, 455-477, Gossey-Bass, in San Francisco, 1968.

4. Barton Russell: "The Psychiatric Hospital:, in H. Freeman and J. Farndale (Eds), Trends in The Mental Health Services - N.Y. -MacMillan, 1963.

5. Cooper, A.E., and Early,D.F., "Evolution in The Mental Hospital" in H. Freeman and J. Farndale (Eds) - Trends in The Mental Health Services, N.Y. - MacMillan, 1963.

6. Brown,G.W., Bone,M., and Dalison, B., and Wing,J.K., Schizophrenia and Social Care. London: Oxford University Press, 1966.

7. Kelly, F., "Research in Schizophrenia", Social Work, 10:32-44, January 1965.

8. Stimpert,W., Sinnett,E., and Wilkins,D., "A Description of Psychiatric Patients Five Years After Treatment", Social Work, 11:78-86, July 1966.

9. Wing,J.K., "Evaluating Community Care for Schizophrenic Patients in the United Kingdom", in Leigh,R., Halleck,S., and Loeb,M.(Eds) Community Psychiatry, University of Wisconsin Press, 1966.

10. Holden,J.M.C., and Klein,H.E., "Problems in the Rehabilitation of Chronic Schizophrenics". Rehabilitation Literature, 28:11, November, 1967.

11. Wing,J.K., "Modern Management of Schizophrenia", in Freeman, H., (Ed.), New Aspects of The Mental Health Services, London: Pergamon Press, 1967.

12. Freedman,A.M., Tertiary Prevention - in Comprehensive Textbook of Psychiatry, A.M.Freedman and H. Kaplan (eds) 1549, - William and William Co. - Baltimore, 1967.

13. Watley, Charles D., "Social Attitudes Toward Discharged Mental Patients" - Social Problems 6:313-320, 1959.

14. Cumming,E., and Cumming,J., Closed Ranks - An Experiment In Mental Health Education, Harvard Univ. Press, 1967.

15. Mayer-Gross,W., Harrington,J.A., and Baker,A.A., "Breaking Up The Mental Hospital", Lancet, 2:697-698, 1958.

16. Hill,A., Ulett,A., and Gildae, "Comprehensive Mental Health Planning in Missouri" Columbia, Missouri-Univ. of Mo. School of Medicine, February, 1966.

17. Brooks, George W., "Rural Community Influences and Support in a Rehabilitation Program for State Hospital Patients" in M.Greenblatt, D.C. Levinson and G. L.Klenman (Eds) - Mental Patients in Transition 133 - 138, Charles C. Thomas, Springfield, Ill. - 1961.

18. Titmuss, R., - "Community Care: Fact or Fiction", H. Freeman and J. Farndale (Eds) - Trend in The Menatl Health Services - London - Pergamon Press, 1963.

19. Barton, R., Institutional Neurosis, Bristol, John Wright & Sons, 1959.

20. Goffman, Erving, Asylums, New York: Anchor, 1961.

21. Vail,D., Dehumanization and the Institutional Care, Springfield, C.C.Thomas, 1966.

22. Scheff, T.J., Being Mentally Ill, Chicago, Aldine Pub.Co.,1966.

23. Sapirstein,S.J., Institutional Transference, Psych. Qt. 41:3: 557-566, 1967.